National Library of Canada
Canadian Theses Service
Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada
Services des thèses canadiennes

CANADIAN THESES

THÈSES CANADIENNES

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

THIS DISSERTATION
HAS BEEN MICROFILMED
EXACTLY AS RECEIVED

LA THÈSE A ÉTÉ
MICROFILMÉE TELLE QUE
NOUS L'AVONS REÇUE

NL 339 (r. 86/01)

Canada

National Library of Canada
Bibliothèque nationale du Canada

151

Ottawa, Canada
K1A 0N4

TC –

0-315-23348-6

CANADIAN THESES ON MICROFICHE SERVICE – SERVICE DES THÈSES CANADIENNES SUR MICROFICHE

PERMISION TO MICROFILM – AUTORISATION DE MICROFILMER

• Please print or type – Écrire en lettres moulées ou dactylographier

AUTHOR – AUTEUR

Full Name of Author – Nom complet de l'auteur

OLGA ALEXANDRA WISKEL

Date of Birth – Date de naissance

DECEMBER 23, 1934

Canadian Citizen – Citoyen canadien

☒ Yes / Oui ☐ No / Non

Country of Birth – Lieu de naissance

CANADA

Permanent Address – Résidence fixe

6322 - 103 AVENUE
EDMONTON, ALBERTA
T6A 0T6

THESIS – THÈSE

Title of Thesis – Titre de la thèse

The Effects of Menopausal Status and Employment on the Psychological Well-Being of Women at Midlife

Degree for which thesis was presented
Grade pour lequel cette thèse fut présentée

MASTER OF EDUCATION

Year this degree conferred
Année d'obtention de ce grade

1985

University – Université

ALBERTA

Name of Supervisor – Nom du directeur de thèse

DR. R. FRENDER

AUTHORIZATION – AUTORISATION

Permission is hereby granted to the NATIONAL LIBRARY OF CANADA to **microfilm** this thesis and to **lend** or **sell copies of the film.**

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

L'autorisation est, par la présente, accordée à la BIBLIOTHÈQUE NATIONALE DU CANADA de **microfilmer** cette thèse et de **prêter** ou de **vendre des exemplaires du film.**

L'auteur se réserve les autres droits de publication; ni la thèse ni de longs extraits de celle-ci ne doivent être imprimés ou autrement reproduits sans l'autorisation écrite de l'auteur.

ATTACH FORM TO THESIS – VEUILLEZ JOINDRE CE FORMULAIRE À LA THÈSE

Signature

Olga Alexandra Wiskel

Date

October 7, 1985

NL-91 (r. 84/03)

Canada

THE UNIVERSITY OF ALBERTA

THE EFFECTS OF MENOPAUSAL STATUS AND EMPLOYMENT ON PSYCHOLOGICAL WELL-BEING IN WOMEN AT MIDLIFE

BY

OLGA A. WISKEL

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF EDUCATION

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL, 1985

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: Olga Alexandra Wiskel

TITLE OF THESIS: The Effects of Menopausal Status and Employment on the Psychological Well-Being of Women at Midlife

DEGREE: Master of Education

YEAR THIS DEGREE GRANTED: Fall, 1985

Permission is hereby granted to THE UNIVERSITY OF ALBERTA LIBRARY to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

Olga A. Wiskel

6322 - 103 Avenue
Edmonton, Alberta
T6A 0T6

Date: October 7, 1985

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled The Effects of Menopausal Status and Employment on Psychological Well-Being in Women at Midlife submitted by Olga Alexandra Wiskel in partial fulfilment of the requirements for the degree of Master of Education.

Robert Fender
(Supervisor)

Date: Sept. 26, 1985

ABSTRACT

The effects of menopausal status, employment, and various socio-demographic variables on psychological well-being in midlife women were explored in this study. Data were collected by means of a mailed questionnaire from 105 women aged 40 to 55 years living in and around Edmonton. Levels of well-being, as determined by instruments measuring depression, affect, and life satisfaction, were found to be similar among the three menopausal groups and the three employment categories. Thus, the perimenopausal group did not have reduced well-being in contrast to the premenopausal and postmenopausal groups. The full-time workers and part-time workers did not experience higher levels of well-being than homemakers. Menopausal status and employment do not appear to have strong effects on well-being in this sample.

Weak but significant correlations were found between depression and the family variable dealing with the number of stillborns, miscarriages, or abortions, and between life satisfaction and years of schooling. No definite explanation could be given and it was concluded that simple relationships are inadequate to explain the complexities of well-being in midlife women.

ACKNOWLEDGEMENTS

I wish to express my sincere gratitude to Dr. R. Frender, my thesis supervisor, for his patience and guidance, and to Dr. C. Yewchuk and Dr. N. Keating, my thesis advisory committee, for their interest and comments.

I wish to thank the persons and organizations too numerous to mention who contributed to the undertaking of this study.

Thanks are given to Anderson, Wiskel, and Associates for use of office facilities and staff in the production of this thesis.

Special thanks are especially given to the volunteers who willingly participated and made this study possible.

Very special thanks are given to my sons Bruce, Bruno, and J. Barry, and in particular, to my husband Stanley, for their love, support, and encouragement.

TABLE OF CONTENTS

CHAPTER		PAGE
I.	INTRODUCTION	1
II.	REVIEW OF THE LITERATURE AND RESEARCH	4
	Well-Being	4
	Definitions and Measure of Well-Being	5
	Factors that Influence Well-Being	9
	Income	9
	Marital Status	9
	Employment	10
	Health	10
	Education	10
	Well-Being of Midlife Women	11
	Effects of Menopause on Well-Being	12
	Effects of Employment on Well-Being	17
	Effects of Marital and Family Variables	22
	Effects of Education	25
	Summary	26
	Purpose of the Study	28
	Research Questions	29
III.	METHODS AND RESEARCH PROCEDURES	30
	Sampling Procedures	30
	Measurement of Psychological Well-Being	31
	Self-Rating Depression Scale	32
	Affect Balance Scale	33

CHAPTER PAGE

Life Satisfaction Index Z..... 33

Measurement of Independent Variables..... 34

Questionnaire E..... 34

Description of Sample..... 36

Age Range..... 36

Menopausal Status..... 36

Employment Status..... 37

Occupational Class..... 37

Volunteer Work Variable..... 37

Educational Variables..... 38

Marital Status and Family Variables..... 38

Pharmaceutical Consumption..... 39

Income Status..... 39

Well-Being Variables..... 39

Summary of Sample Characteristics..... 43

Analysis of Data..... 45

IV. RESULTS..... 46

Relationship Between Well-Being and Menopausal Status.... 46

Relationship Between Well-Being and Employment Status.... 48

Well-Being as Related to Various Variables..... 48

Summary of Results..... 51

V. DISCUSSION..... 53

Menopausal Status as a Factor in Well-Being..... 53

Employment as a Factor in Well-Being..... 55

The Effect of Other Factors on Well-Being..... 56

CHAPTER PAGE

Limitations of the Study..... 57

Conclusions and Future Research Directions..... 58

BIBLIOGRAPHY..... 61

APPENDIX A. COVERING LETTER AND QUESTIONNAIRES..... 67

LIST OF TABLES

Table	Description	Page
1	Frequency and Percentage Distribution of Respondents by Income	40
2	Frequency and Percentage Distribution of Respondents for Depression Scores	41
3	Frequency and Percentage Distribution of Respondents for Affect Balance Scores	42
4	Frequency and Percentage Distribution of Respondents for Life Satisfaction Scores	44
5	Well-Being Means of Sample by Menopausal Status	47
6	Well-Being Means of Sample by Employment Status	49
7	Correlation Coefficients of Sample for Measures of Well-Being	50

CHAPTER I

INTRODUCTION

Although Neugarten and associates (1975) consider menopause to be one of the three significant biological events in a woman's life (the other two being menarche and pregnancy), in contrast to menstruation and other feminine physiological issues, menopause is still relatively ignored or poorly researched (McKinlay & McKinlay, 1973; Bart & Grossman, 1978; Posner, 1979). Furthermore, most research on the menopause has traditionally been undertaken from the perspective of male physicians and has focused on endocrine deficiency and symptomatology occurring during the midlife period of women (Flint, 1979; MacPherson, 1981; Vancouver Women's Health Collective, 1984).

For years, menopause was considered to be a major negative influence in the midlife period of women. This negative perception arose because discomfort and distress can accompany the physiological symptoms of menopause and because psychological losses can occur at this time and be ascribed to menopause. However, no reliable estimate of the proportion of women experiencing these negative effects of menopause has emerged because attention has focused to a large extent on clinical populations of women who presented symptoms and complaints. Also, no consistent and relatively objective definition has been used to identify subjects in menopause.

In recent years, a small but increasing number of physicians and behavioral scientists have been studying the menopause from the psycho-socio-cultural perspective (Parlee, 1976; Flint, 1979; Cutler et al.,

1983). As a consequence, many aspects of menopause which had been previously characterized in negative or pathological terms are now being addressed as natural and positive events for women. Menopause is now being viewed as a natural biological event experienced universally by all women which coincides with a variety of other factors, social and personal, that may also influence a woman's life. The social construction of menopause as a disease is being dismantled (MacPherson, 1981).

As is the case for menopause, little research exists on the influence of working status for women; the majority of the literature on employment has been concerned with the male work role, the well-being of employed males, and the importance of occupational status on identity and self-worth for men (Neff, 1977; Coleman & Antonucci, 1983). Greater participation of women in the labor force in both Canada and the United States during the past two decades (Statistics Canada 1982, reports that 56.6% of women over 15 years of age are in the Canadian labor force in contrast to 34% in 1973 and 27.7% in 1963), necessitates the greater examinination of the influence of employment on women's lives.

Barnett and Baruch (1978) recommended that studies of women in their middle years should consider other factors that affect women's lives rather than focus solely on reproductive status such as menopause. By examining employment status and other sociodemographic variables, as well as menopausal status, my study provides a multivariate approach to understanding psychological well-being in women at midlife.

In the present study, I investigated the relationship of menopausal status, employment status, and other variables to well-being in midlife women aged 40 to 55 years of age. Using relatively objective definitions of the phases of menopause, the study compared a sample of middle-aged women grouped on the basis of menopausal phases and employment categories to determing if differences in well-being existed between these groups.

CHAPTER II

REVIEW OF THE LITERATURE AND RESEARCH

To understand the impact of menopausal status and employment status on the well-being of midlife women, it is first necessary to define well-being before reviewing the existing evidence about the relationship of these two life situations to well-being in midlife women. Other conditions that influence well-being in midlife women will also be discussed: marital status, family variables, income, and education. The chapter concludes with a summary of the previous research, the purpose of my study, and an outline of the questions I investigated in my research.

Well-Being

Although research on well-being has been carried on in the field of gerontology for the past 40 years, it is only during the past decade that well-being has gained prominence as a construct in psychology (Diener, 1984). Philosophers throughout history have considered happiness to be the highest good and Lawton (1983) reaffirms this "common wisdom that we would rather feel good or neutral than feel distressed." Psychologists have focused almost exclusively on abnormal psychology (in the case of midlife women, on clinical populations and disturbances in the menopause) rather than on what Warr (1978) refers to as normal psychology. Well-being is concerned with the positive ways in which people experience their lives.

Definitions and Measure of Well-Being

Diverse terms such as happiness, satisfaction, morale, adjustment, and contentment have been used interchangeably in studies utilizing the concept of well-being (Lohmann, 1977; Larson, 1978; Diener, 1984). Warr (1978) acknowledged this diversity by defining well-being as a "malleable concept" dealing with people's feelings about their everyday activities, and observed that "several facets of well-being are conceptually and statistically distinct but overlapping.....well-being not being the same as happiness although the latter is a component of the former.' Subjective well-being is becoming the preferred term because current research relies almost exclusively on self-reports (Larson, 1978), and because this construct refers to a phenomenon within the individual (Diener, 1984). Two other hallmarks are the inclusion of positive measures of well-being not just the absence of negative factors, and the consideration of a global assessment of all aspects of a person's life (Diener, 1984).

Diener (1984) categorized definitions of well-being into three groups. In the first group are definitions that prescribe normative standards for what is desirable and against which people's lives can be judged; well-being is not thought of as a subjective state, but as possessing some desirable quality. Definitions labeled life satisfaction, in which people make assessments of their quality of life according to their own chosen criteria, form the second group. These definitions rely on the standards of the individual to determine what is the good life. The final type of definition, which is similar to the meaning used in everyday language, stresses the presence of pleasant emotional experience that has resulted from a preponderance

of positive affect over negative affect.

Lawton (1983), examining the issue of whether well-being represents a single domain or a multidimensional one, justified both views. Measures of well-being as a unidimensional construct include the Kutner Moral Scale and various single item measures of satisfaction or happiness; they are appropriate when only a brief or broad indication of well-being is required (Larson, 1978). Shortcomings of unidimensional measures include their inability to measure separate dimensions of well-being and their unreliability over time (Diener, 1984).

Neugarten, Havighurst, and Tobin (1961), critical of the unidimensional approach to psychological well-being, identified five components when developing their life satisfaction instruments. They asserted that a high level of well-being results to the extent that the individual (a) gets pleasure from daily activities (b) regards life as meaningful (c) feels s/he has succeeded in achieving her/his major goals (d) holds a positive image of self and (e) maintains happy and optimistic attitudes and mood.

Campbell (1976), reviewing the literature that studied subjective indicators of well-being, identified three approaches. One approach conceptualized well-being as a cognitive experience with the individual comparing her/his perception of the present situation to the situation s/he expected or aspired to. A second approach viewed well-being as an affective experience concerned with subjective feeling states such as happiness. The final approach regarded well-being in terms of relative freedom from anxiety, distress, or other psychiatric symptoms.

In research dealing with happiness, Bradburn and Caplovitz (1965) found an independence between positive feelings and negative feelings;

both correlated with happiness, but not with each other. Bradburn and Caplovitz suggested that, unlike conventional notions about well-being, a person with negative feelings was also likely to possess positive feelings. Their interpretation was that well-being is a joint function of the forces contributing to positive and negative feelings, but forces that produce negative feelings do not necessarily reduce positive feelings and conversely, the presence of positive feelings does not necessarily diminish negative ones. A balance of positive and negative feelings accounts for the functioning of an individual.

Lawton (1983) presents psychological well-being as one of four sectors comprising "the good life" and defines psychological well-being as "one's subjective evaluation of the overall quality of one's inner experience." Lawton's observation that "other things being equal..... we would rather feel good or neutral than feel distressed" emphasizes the importance of well-being for individuals. Lawton identifies four aspects of psychological well-being. The first is labeled neuroticism and includes anxiety, depression, agitiation, worry, pessimism, and other distressing symptoms. The second is called happiness and represents a cognitive judgment of the positive affect over a relatively long but indefinite time interval. The third, positive affect, provides a description of an emotional state rather than a cognitive judgment. The fourth and final aspect of Lawton's model represents a congruence between desired and attained goals.

In conclusion, although a variety of definitions, employing somewhat different factors and producing different measurement instruments, exist, there is some similarity among the various definitions. A positive affect factor is present in the definitions of Neugarten

et al., Bradburn and Caplovitz, Campbell, and Lawton. Lawton's congruence between desired and attained goals, Neugarten and associates' successful achievement of main goals, and Campbell's concept of cognitive comparison appear to share the similarity of a cognitive factor. Lawton's neuroticism factor and Campbell's freedom from psychiatric symptoms both involve a dysfunction or lack of well-being.

That most measures correlate moderately with each other also suggests a strong underlying common source of variance related to subjective well-being (Diener, 1984). Lohmann (1977) found a high level of interrelationship among the frequently used measures of life satisfaction, adjustment, and morale (but a lower correlation between the single item question and other measures), which she interpreted as an indication of a common underlying construct. Larson (1978) also reported high correlations among measures of life satisfaction, morale, and related variables which he believed justified considering them as aspects of a single summary construct, subjective well-being.

Because the happiness factor, the life satisfaction judgment factor, and the psychiatric factor show a high to moderate correlation with each other, these three factors formed the basis for the measurement of well-being in my study. Although Diener (1984) dismissed the use of psychiatric distress instruments to measure well-being, inclusion of the Self-Rating Depresssion Scale served to check the absence of well-being as well as to measure this condition which has been reported to be more prevalent in women (Scarf, 1981).

Factors that Influence Well-Being

Diener (1984) notes that, although conditions such as wealth or health are not considered to be parts of well-being, such conditions are seen as influencing well-being. Several conditions that possess a relationship with well-being have been identified. Income and marital status show a consistent, but small, relationship with well-being, while employment, health, and education show more tenuous relationships. One reason why their influence is not greater may be that they do not directly effect well-being, but are mediated by subjective judgment (Diener, 1984). The effects of these five influences will now be discussed.

Income. Much evidence exists showing a positive relationship between income and well-being (Diener, 1984). Larson (1978), reviewing well-being studies of older Americans, found a clear relationship between low income and lowered expressed satisfaction with life. In general, it appears that wealthier persons in a country are happier than poorer persons in the same country. However, the influence of income may be relative as happiness does not rise with an increase in income. This suggests that any addition to an income already sufficient for maintaining a reasonable level of well-being becomes less consequential to well-being.

Marital Status. Numerous studies have found that married persons report higher average well-being scores than any category of unmarried persons (Robinson & Shaver, 1976; Larson, 1978; Diener, 1984). In his review, Diener (1984) found that marital satisfaction is one of the most important predictors of well-being and that marriage has an effect on well-being because previous divorce is not related to the

happiness of persons who are remarried. Married men derive definite benefits from marriage as shown by the lowered admission rates of married men to mental hospitals, but some studies question the benefits of marriage for women's well-being (Hare-Mustin, 1983). Further discussion on this topic will be found in a later section.

Employment. Unemployment has been shown to have a negative impact on well-being of both men and women (Warr & Parry, 1982). Besides the obvious financial hardships resulting from unemployment, benefits of employment such as opportunities for task achievement, establishment of social networks, and the presence of a temporal structure are also lost through unemployment (Warr, 1982). The effects of employment on women will be discussed in more detail in a later section.

Health. In older persons, health is the element most strongly related to well-being; those who are ill or physically disabled are less likely to express happiness (Larson, 1978). The studies relating health and well-being in the general population are mixed, some reporting sizeable figures and others low correlations, but self-rated health is more strongly correlated with well-being than objective health (Diener, 1984). Part of the influence of health on well-being is not only how people feel but what their health allows them to do. Furthermore, Cutler (1973) noted that healthy people are more likely to participate in volunteer activities, whereas people with poor health are more likely to withdraw from participation. In this regard, research studying the association between health and well-being in volunteer subjects is of questionable value if the sample is all healthy.

Education. The correlation between education and well-being is small when statistical controls are introduced, and education seems to

interact with other variables such as income (Diener, 1984). However, these low correlations may mask a stronger curvilinear relationship, as for example, the report of high well-being by older persons at middle levels of education (Larson, 1978). Robinson and Shaver (1976) also reported that the more educated had higher levels of satisfaction, but high levels were reported by individuals with low education and high income, and low levels were reported by individuals with high education and low income. Education may therefore, produce frustrations by increasing aspirations and expectations that cannot be satisfied (Glenn & Weaver, 1981). Several studies, which well be presented in a later section, have indicated more positive effects of education for women.

Well-Being of Midlife Women

The midlife period of women has been described in various ways. Climacteric or climacterium, derived from the Greek word for the top rung of the ladder, is one such synonym. Climacteric may refer to either the transition from the reproductive stage of life to the non-reproductive stage in women (Flint, 1979), or to a period of time from approximately age 45 to 60 in which gradual changes occur in all body tissues for both men and women (MacPherson, 1981). Cherry, (1976) utilizes this term when dividing the life of a woman into five phases: childhood, puberty, maturity, climacteric, and old age.

The years during which midlife occurs have been placed at various times. Thirty-seven years is one marker because it is half of the 75 year life expectancy for women, and the 45 to 60 years of the climacterium previously mentioned is also a marker. Census takers quote 45 to 54 and 55 to 64 figures, and the range 45 to 55 is often given

because the majority of women cease menstruation during this decade, whereas the United States Social Science Council indicates 40 to 60 years as marking midlife (Fuchs, 1977).

Whatever the label or time span, midlife has become a significant period in the lives of women. Women are no longer accelerated from adulthood into a quiet life of old age as was commonly prescribed by Victorian Age physicians (MacPherson, 1981), but experience the middle years as a period of growth and development as unique and important as any previous life interval. However, the midlife period of women continues to be labeled negatively (Carney, 1982), because of harmful myths which psychotherapist Dr. Rita Ransohoff claims are still maintained in our society (Carney, 1982), and because of the persisting view of menopause as a deficiency disease (MacPherson, 1981). The study of the impact of menopause on the well-being of middle-aged women requires the examination of other important factors such as employment status, marital status, educational level, and family variables including the departure of children.

Effects of Menopause on Well-Being

The psychoanalyst, Helene Deutsch (1945), considered menopause to be a traumatic experience which resulted in depression and a "partial death" as a consequence of women's realization that their "service to the species ceases" and that their feminine qualities disappear. According to Deutsch, these losses of femininity and reproduction explain the depression experienced by women.

Ruth Lax (1982), a present-day psychoanalyst, continues to support the "expectable climacteric depressive reaction" and the

reduced sense of well-being that results from phase-specific physiological changes and symptoms. Lax declares that the "expectable depressive reaction" manifests itself as a mourning process for the youthful self of ones' past and that mourning is necessary for successful progress toward "greater psychic maturity." However, neither Lax nor Deutsch presents empirical evidence to uphold their views that depression is an inevitable and necessary component in the lives of midlife women.

Several studies conducted in gynecological out-patient clinics in England found an overlap of gynecological and psychiatric problems with the association more marked in midlife women. Munro (1969) reported that half of the first attenders at a gynecological clinic were women in the menopausal age. A high prevalence of minor psychiatric illness in women aged 40 to 55 years who were new patients at a gynecological out-patient clinic was reported by Ballinger (1975). Also, in a survey of 539 women, aged 40 to 55 years from the general population, Ballinger (1975) found a higher incidence of psychiatric illness in menopausal women than in pre- or postmenopausal women.

However, Myrna Weissman (1979), studying three age groups of depressed women, reported neither a unique pattern nor greater amounts of depression for menopausal women and concluded that specific menopausal depression does not exist. In the late seventies, the removal of Involutional Melancholia (a depression associated with involutional or degenerative processes such as ovarian degeneration) from the Diagnostic and Statistical Manual of Mental Disorders, confirmed the failure to identify a menopausal depression (Scarf, 1981).

Other symptoms of reduced well-being, which were attributed to

menopause, were labeled under the title of menopausal syndrome (Weideger, 1980). One of the first studies to investigate the incidence of symptoms attributed to menopausal changes was conducted by Neugarten and Kraines (1965) across five age groups of well-population samples. Neugarten and Kraines found that adolescents and menopausal women reported the largest number of symptoms and suggested that endocrine-related changes involving low and high production of estrogen may be implicated and that social psychological stress may be greater in these two developmental periods. However, because postmenopausal women, despite reduced estrogen levels, report the fewest symptoms, this suggests the existence of a factor mediating their reaction to biological development.

Other studies investigating symptoms directly attributed to the menopause found that hot flashes or flushes (these terms are used interchangeably) and night sweats (hot flashes which occur at night) were the only ones definitely correlated with the onset of a natural menopause, occurring in about 75% of the women (Thompson, Hart, & Durno, 1973; McKinlay & Jefferys, 1974; Bungay et al., 1980; Sherman et al., 1981). McKinlay and Jefferys (1974) found that other symptoms such as headaches, dizzy spells, palpitations, sleeplessness, depression, and weight gain showed no direct relationship to the menopause, but tended to occur together, leading these two investigators to conclude that such symptoms are not directly related to the menopause.

A recent study (Polit & LaRocco, 1981) provided further evidence that hot flashes are a distinct menopausal symptom, since this symptom was not related to any of the social psychological variables present in the study. That this somatic complaint is less susceptible to the

influence of personality and demographic factors, suggests that certain aspects of a woman's personality predispose her to experience the so-called menopausal syndrome. Symptoms, other than hot flashes, said to be related to menopause may be more likely related to a woman's personal characteristics (whether or not she is in the climacteric) than it is the menopause itself.

Flint (1976) believes that cultural attitudes may be responsible for the greater number of women with symptoms in Western cultures than found in other cultures. From her study of Rajput caste women in two states in India, Flint (1975) found very few women experienced menopausal symptoms and suggested that these women look forward to menopause because they achieve a greater status at that time. Because aging is viewed negatively and youth is extolled in the United States (Flint, 1979), American menopausal women receive little positive feedback from their culture and their status, in contrast to that of Rajput women, is declining. American women could be said to be punished rather than rewarded for achieving menopause (Flint, 1975).

The cause of the hot flashes is unclear and may be related to a hormonal imbalance rather than simple estrogen deficiency (Notman, 1979). Weideger (1980) believes that suggestions of an overabundance of FSH (Follicle Stimulating Hormone) or over-activity of the pituitary are questionable, as younger women having such physiological conditions do not have hot flashes. Marx (1980) reports on studies that implicate LH (Luteinizing Hormone) and the hypothalmus; centers in the hypothalmus which stimulate LH production and regulate temperature are located near each other. Sherman and associates (1981) could not identify women by menstrual, reproductive, or medical variables who

were more likely to develop the vasomotor symptoms in menopause.

Estrogen replacement therapy (ERT), now also called HRT (hormone replacement therapy), has been found to be effective in relieving th vasomotor symptoms of hot flashes and absolutely necessary following surgical removal of both ovaries, which produces a drastic reduction of estrogen and an immediate menopause (Cutler et al., 1983). As estrogen naturally stimulates the growth of many tissues including fibroids and tumors already existing, supervision of women taking estrogen is essential. A controversy exists between those who prescribe ERT after symptoms appear, then discontinue treatment after six months or one year, and not resume treatment until symptoms reappear, and those who prescribe ERT before symptoms appear and continue treatment for the rest of a woman's life.

Dr. Robert A. Wilson (1966) made claims for ERT in Feminine Forever that assured the prevention of menopause and a lifetime of being young and feminine. However, some of Wilson's assertions are misleading, or overstated, because menopause will happen when the ova are eventually depleted leading to the cessation of fertility.

Removal of the uterus, hysterectomy in medical terminology, is sometimes prescribed for distressful menopausal symptoms, permitting a greater sense of well-being when physical and organic conditions indicate the necessity for surgery (Cutler et al., 1983). Cutler and associates (1983) reported that, although the incidence of hysterectomy had been rising in the United States from 1962 when 31% of menopausal women had hysterectomies to the 59% reported in 1975, incidence of hysterectomy appears to have stabilized at the 50% level in 1983. Mendelsohn (1981) questions the supposed benefits of sexual pleasure

following hysterectomy. He reports studies that found reduced sexual drive in 60% of women having both uterus and ovaries removed, and up to 42% of women after hysterectomy abstained from sexual intercourse.

Tranquillizers are often prescribed for so called "mild menopausal symptoms" such as insomnia or irritability; however, this may reflect a "medical attitude that lacks depth and responsibility", representing an easy way out for a physician who does not want to take the time or trouble to treat symptoms during the menopause that may relate to other conditions (Weideger, 1980). Nellis (1980) reported that during one year, 36 million women in United States used tranquillizers and that over 70 percent of prescriptions written for tranquillizers were for women.

Effects of Employment on Well-Being

In a discusssion of employment in general terms, Warr (1982) identified six advantages and four disadvantages of paid employment. The benefits of paid employment are: (a) money as a means to various gains (b) activity as an outlet for physical and mental energy (c) variety for unchanging domestic surroundings (d) temporal structure to employment responsibilities and to leisure activities (e) social contacts for support and social comparison and (f) status and identity within society. The disadvantages are: (a) tedious and boring jobs (b) jobs with overload and excessive responsibility (c) work having environmental detriments and (d) work which involves conflict and troubled interpersonal relationships. However, Warr (1982) concluded that the psychological benefits of paid employment outweighed the costs.

Welch and Booth (1977), reviewing earlier studies on employment

and women, found that many focused primarily on the effects of employment on children and husband-wife relationships. One view found that employment outside the home was detrimental to the well-being of married mothers because of the extra burdens placed on the mother. In particular, employment may be a hardship for working class mothers forced to take low paying and low skill jobs without resources to hire outside household and child care help. The other belief is that employment is beneficial to the well-being of married mothers because women find their family role more confining than do men. Married men have at least two major sources of gratification, job and family; homemakers have only one, the family. Work outside the home gives women an identity and purpose in addition to being wives and mothers (Gove, 1972). Also, being a homemaker may be conducive to depression because of the low value and low prestige given to this role and because of the acute loss felt when children leave home if overinvolvement in the maternal role has occurred (Bart, 1972).

An early study by Briggs, Laperriere, and Gredan (1965) analyzed the effects of employment on middle-aged women and found a lower prevalence of depression among working women. Briggs et al. concluded that employment supplies protection against depression by providing environmental supports in the form of vocational ties at a time when children are leaving home.

Mostow and Newberry (1975), comparing a patient population of depressed housewives with a matched group of depressed working women aged 25 to 60 years, found the workers recovered faster and showed more overall improvement than did the housewives. Also, the workers felt more competent in their work, less frequently bored in their free

time, and more at ease in social situations. The authors suggested that working offered women some protection and distraction and that women in higher risk groups, such as menopausal women and widows, might benefit from employment that increases their self-esteem and reduces their feelings of worthlessness.

The finding that housewives felt less satisfied in their work than women employed outside the home was reported by Ferree (19[redacted]) and Newberry, Weissman, and Myers (1979). Ferree's working class sample revealed that a larger percentage of housewives (26%) were dissatisfied with their work than either part-time or full-time workers. Ferree stated that one drawback was the lack of recognition of housework as valuable work; even for unskilled workers free to retire, paid employment employment provided a source of independence and self-esteem not available to lonely and socially isolated homemakers. Newberry et al. (1979) showed similar findings from their study of female workers and housewives and concluded that the role of housewife in modern industrial society is isolated, restrictive, and devalued.

Wright (1978), analyzing data from six large national surveys conducted between 1971 and 1976, found no significant differences in life satisfaction between full-time housewives and women who work outside the home. Wright concluded that both groups have benefits and costs attached to their work but the net satisfaction amounts to approximately the same for each group.

Ivancevich and Matteson (1982) investigating a sample of full-time and part-time homemakers randomly selected from high and middle income areas, found both groups were equally satisfied with the homemaker role. From these findings the investigators could not support

the suggestion that homemaking is lifeless, boring, or understressful.

Three studies examining the effect of employment on midlife women found advantages accruing for employed women. First, Lowenstein and associates (1981), studying the satisfactions and stresses of single women in midlife, found life satisfaction significantly correlated to investment in work for single women. Fifty-two women of a sample of sixty described their work as "very important"; work was not only seen as a necessary economic activity but as giving meaning to their lives.

Next, Polit and LaRocco (1980), exploring the effects of various factors in a sample of women aged 40 to 60 years, found that women who reported a higher number of symptoms were less likely to be working. Employed women reported significantly fewer symptoms ($\underline{M}$ = 3.3) than non-employed women ($\underline{M}$ = 4.3); women working full-time were less likely to report a symptom than women in the other two categories. For example, 17.5% of full-time working women compared with 51.9% of part-time workers and 45.1% of the non-employed respondents reported having trouble sleeping. In many respects, part-time workers tended to resemble non-employed women more than they resembled full-time workers in regard to reporting of symptoms. (This evidence about part-time workers contrasts with findings reported by Spreitzer and associates (1975) who found part-time workers with an education of 13 years or more to have greater avowed happiness and to experience more excitement in life than either full-time workers or housewives.)

Coleman and Antonucci (1983) hypothesized that a woman's involvement in work would minimize psychological anxieties associated with middle age, and that working women would have greater psychological

well-being than homemakers who were not working outside the home. Data were taken from a national survey, and the sample of women 40 to 59 years of age was selected to represent the middle-age group. Results indicated that working women scored significantly higher on most measures of psychological well-being than homemakers, but did not differ on the Zung Depression Scale. Coleman and Antonucci interpreted the results as indicating that possible negative effects of the midlife period are attentuated if a woman is employed. Employment serves as a deterrent to psychological anxiety by acting as a stabilizing element in this difficult period for women of changing family roles and existential issues, and as a distractor which draws attention from midlife problems.

In a comprehensive article, Warr and Parry (1982) discussed some important features involved when examining the relationship between paid employment and women's psychological well-being. Warr and Parry emphasized that women's well-being is influenced by many factors of which employment is but one. They recommended that multivariate investigations, utilizing life cycle stages, socioeconomic status, domestic setting, and other features in a woman's life, be carried out, instead of studies using employment status as a single variable.

Warr and Parry (1982) proposed a three-component framework which contained the important variables that mediate the relationship between employment and women's well-being. These three components are occupational involvement, the quality of a woman's nonoccupational environment, and (if she has a job) the quality of her employment relationship.

Occupational involvement basically involves a woman's marital

status and parental status. For example, a single woman without children who strongly wants a job would be said to have high occupational involvement. The quality of the nonoccupational environment is an important mediating factor in that work may provide what is lacking in the nonoccupational environment or, if unable to provide this, may at least provide relief from adverse conditions in the nonworking environment. Lastly, the quality of the employment relationship must be recognized in order to determine whether the relationship is rewarding or not, and whether the demands of employment conflict with the woman's nonoccupational role. When two of the components combine against a positive outcome, paid employment is not likely to have any influence in well-being.

Effects of Marital Status and Family Variables

Although marital status has been related positively to well-being (Diener, 1984), this relationship has implications for women. General agreement exists that married people experience higher levels of psychological well-being than any category of unmarried persons (Glenn, 1975; Radloff, 1975; Diener, 1984), but evidence exists that married women experience higher rates of mental illness than married men (Gove, 1972; Radloff, 1975; Hare-Mustin, 1983).

Gove (1972) suggested that the higher rates of mental illness for married women could be attributed to their role. This role is fragile because only one source of gratification exists, the family, and if this is not fulfilling, no other source is available. Next, the instrumental element to this role, housekeeping, is perceived as frustrating, unskillful, and being of low prestige. Furthermore, the role

is unstructured, invisible, and devalued in society.

Hare-Mustin (1983) suggests that it is the demands of the traditional sex role and the typical sterotyping of women in one role, the family role, which has resulted in more problems for married women than for married men. Hare-Mustin further declares that these problems may be erroneously identified as psychiatric disturbances, when they should be considered as women's problems in living due to social, economic, or legal conditions. "Certain aspects of women's sex roles may influence the development of mental illness such as holding in negative feelings, behaving to satisfy a male partner, passivity, learned helplessness, exaggerated femininity, and other-directedness.

However, Glenn (1975a) rejects the statement that marriage is more beneficial for men by reporting that two of three United States national surveys showed a stronger relationship of marital happiness to global happiness for wives, while reporting similar levels or marital happiness for husbands and wives. Glenn suggests that the benefits of marriage are strong enough to outweigh, in the balance of positive and negative effect, the stressful consequences of marriage for women.

Divorced women and widows have lower scores of well-being than married women (Glenn, 1975a; Spreitzer et al., 1975; Diener, 1984). Widowhood begins to be a reality to many midlife women who are in their fifties and by 65 years, 36% of women are widows (Atchley, 1977). Widows were found to have higher levels of depression and lower levels of adjustment than widowers except for widows with college degrees who were the only group of widows with scores in the well-adjusted level (Carey, 1977).

Most studies find either negligible or negative effects on well-

being of having children (Diener, 1984). Polit and LaRocco (1980) in their sample of middle-aged women found that women checking depression as a symptom had a significantly larger number of children ($\underline{M}$ = 3.5) than women who did not check this symptom ($\underline{M}$ = 2.6).

A large amount of attention in past years had been directed to the time that the last child leaves home. The "empty nest syndrome" described the depressive reaction in middle-aged mothers attributed to the loss of the maternal role and of rewards accompanying this role when children have grown up and "left the nest" (Radloff, 1980). However, the notions of an "empty nest syndrome" that results in depression, identity crisis, and a decline in well-being of midlife mothers is being eroded as increasing evidence has lessened its credibility (Glenn, 1975b; Harkins, 1978; Radloff, 1980). Results seem to indicate that well-being increases in "empty nest" parents and that depression, if it exists, is rare and of slight duration (Radloff, 1980).

Glenn (1975b) found from the data of six United States national surveys, that middle-aged women whose children have left home report somewhat greater happiness and enjoyment of life than women of similar age with a child (or children) living at home. Glenn concluded that children's leaving home does not typically have an enduring negative effect on the mothers, but rather the effects seem to be moderately positive on balance. Harkins (1978) also found that effects of the "empty nest" as slightly positive and that any effects have largely disappeared within two years following the event. However, being off-schedule with respect to expected timing of the event appears to have adverse effects.

Radloff (1980), in a large community mental health survey, found

that parents (both mother and father) whose children were not living with them were significantly less depressed than respondents (of comparable age, income, occupation, and marital status) whose children were still living with them or respondents who never had children. Radloff also found older parents (40 to 64) with preschool children had higher depression scores than those parents with older children.

The "empty nest syndrome" is more likely to occur for a particular cohort of women due to their unique social circumstances (Borland, 1982). Borland identified the cohort group of white American women born between 1920 and 1939 as being favorable to development of the syndrome because of socialization. As well, Mexican-American women who move to urban areas and lose the buffering effect of being in close proximity to other family members are also predisposed to this syndrome.

Effects of Education

Education, found to be an influencing factor in United States during the years from 1957 to 1978, now does not appear to have a strong effect except for women (Diener, 1984). Several studies have indicated such an effect (Carey, 1977; Polit & LaRocco, 1980; Glenn & Weaver, 1981; Spreitzer, Snyder, & Larson, 1975).

Glenn and Weaver (1981) found that all total effects of education were positive for white females aged 25 to 54 years in their sample drawn from six General Social Surveys carried out from 1973 to 1978. The authors state that the reason for this result may be that women have a less utilitarian approach to education, reaping benefits beyond education's economic and vocational utility for the individual. Glenn

and Weaver present some claims of education that supposedly extend beyond these two utilitarian values. Education, allegedly, can enable individuals to live richer, more interesting, and more satisfying lives. Also, education should sharpen aesthetic appreciation, impart resources for satisfying use of leisure time, help in establishment of successful interpersonal relationships, and develop skills and understandings to help with virtually any of life's problems.

Education was positively related to adjustment for widows in a study carried out by Carey (1977). The widowed women with a college degree were the only widows to achieve scores in the well-adjusted range.

Polit and LaRocco (1980) found that women with more education were less likely to report experiencing symptoms than those with lower levels of education. For example, 64% of women who had not graduated from high school reported depression as a symptom while only 19% of the women with a college degree or greater checked depression as a symptom.

Summary

Well-being is a construct utilized in psychology to indicate the positive aspects of an individual's internal life. Various definitions and measures of well-being have been developed and factors influencing well-being have been identified. Some factors of well-being are more pertinent for middle-aged women because of the conditions present in that period of life.

Menopause is one condition that occurs only in the lives of middle-aged women, and despite evidence to the contrary, continues to

be considered as a source of reduced well-being. Studies have shown that hot flashes and night sweats occurring in approximately 75% of women are the symptoms definitely correlated with a natural menopause. However, a minority of women, approximately 10%, experience these symptoms severely enough to seek medical treatment which may consist of ERT. Various other symptoms, such as headaches and dizzy spells, which have been gathered under the title of menopausal syndrome, have been found to show no direct relationship to menopause. Depression, which has been associated with menopause, does not occur more frequently during midlife, nor does a distinct symptom pattern exist for depressed patients who are in the menopausal years.

Employment for women has advantages and disadvantages which determine whether a woman will benefit from employment. One advantage is that the work role enables women to not rely solely on the family role for gratification and fulfillment. A disadvantage is that employment places burdens on women in addition to their family responsibilities. Employment for midlife women has been found to be beneficial because employment acts as a stabilizing element during this time of changes and as a distractor from other midlife problems.

Although some evidence is contrary to this view, marriage appears to have an advantageous effect on the well-being of middle-aged women. Generally, the positive effects of marriage override the stressful and negative effects for women. The last child's departure from home also appears to increase the well-being of midlife women except when unique social circumstances present themselves. Education beyond high school tends to produce an elevating effect on the well-being of midlife women.

Purpose of the Study

Although previous research on the menopause has disclosed that only a small percentage of women experience severe symptoms directly attributed to menopausal changes, popular belief and the view of some psychoanalysts continue to perceive the menopausal or perimenopausal period of life as one of reduced well-being. Few investigations have been undertaken to study directly the relationship between well-being and menopausal status or to use objective definitions of menopausal status. A recent study by Polit and LaRocco (1981) asked middle-aged subjects to evaluate their own menopausal status and checked this reply by also asking subjects to state the time of their last menstrual period. However, this approach fails to consider changes in volume and regularity which would also identify perimenopausal women.

By employing an objective definition of menopausal status, this study provides a more accurate assessment of the menopausal status of subjects in the sample. Also, by accurately identifying women in the three menopausal phases, evaluating their well-being, and comparing the levels of well-being among the three groups, the study would disclose whether menopausal or perimenopausal women have reduced levels of well-being. Furthermore, employment status and other sociodemographic variables also considered in the study will provide additional sources of influence on well-being instead of reliance upon the sole variable of menopausal status.

This study, thus, improves upon previous studies on midlife women by using an objective definition of menopausal status, and adds more information to the presently scant and insufficient amount of literature dealing with the well-being of midlife women by employing a

variety of variables besides menopausal status.

Research Questions

The preceding information in this chaper has presented the basis for the concerns of my study regarding the relationship of well-being of midlife women to menopausal status, employment status, and other pertinent variables. From this background, the following research questions have been formulated.

Research Question 1

Is well-being in midlife women reduced during the perimenopausal phase in contrast to the premenopausal and postmenopausal phases?

Research Question 2

Do midlife women who are employed outside the home in either full-time or part-time work experience higher levels of well-being than homemakers?

Research Question 3

Does a relationship exist between well-being in midlife women and other variables (age, marital status, occupational class, student status, volunteer status, volunteer hours of work, family, hysterectomy, ovarectomy, educational level, years of schooling, pharmaceutical consumption of estrogen, birth-control pills, tranquillizers, and sleeping pills, and yearly income according to three types) investigated in this study?

CHAPTER III

METHODS AND RESEARCH PROCEDURES

Sampling Procedure

In order to recruit both homemakers and working women as required for the study, notices requesting voluntary participation for a study on women appeared in The Examiner, a weekly publication distributed city-wide, in newsletters of assorted organizations with a large female membership such as the Edmonton YWCA, and on Bulletin Boards of various places of work employing large numbers of women. Direct approach was carried out at two workshops for midlife women conducted by the Women's Program of the Faculty of Extension, University of Alberta, and at several women's curling and bowling leagues and bridge clubs.

One hundred and forty-four women consented to participate and received the measurement instruments by mail during a period from November, 1984 to February, 1985. One hundred and five questionnaires were returned resulting in a 72.9% response rate; nine replies were discarded because of incompleteness or because respondents exceeded the age limit.

The package mailed to the volunteers consisted of a covering letter, a large sealed envelope containing Section #1 and Section #2, and a large stamped envelope addressed to the author (see Appendix A). Instructions printed on the front of the sealed envelope and in the covering letter, stated that Section #1 was to be completed before looking at Section #2. Section #1 consisted of three instruments

measuring psychological well-being: the Self-Rating Depression Scale (Part A), the Affect Balance Scale (Part B), and the Life Satisfaction Index Z (Part C). Section #2 contained statements expressing Attitudes Toward the Menopause devised by Neugarten and associates in 1963 and attitudes toward menstruation composed by me (Part D) and various sociodemographic variables (Part E) selected by me. Part D was found to be beyond the scope of this study and was not analyzed.

Measurement of Psychological Well-Being

Because my review of the literature indicated that well-being is a multidimensional construct, I decided to measure the three dimensions that seemed most centrally associated with well-being: the psychiatric factor, the happiness factor, and the life satisfaction factor. The Self-Rating Depression Scale (SDS) was chosen to measure the psychiatric factor because it was a reliable and valid instrument for identifying depression in a group of psychiatric patients. The Affect Balance Scale (ABS) was selected to measure the happiness factor because it was the only scale that incorporated the two dimensions of positive affect and negative affect which Bradburn (1969) argued to be important components, and because it had more items than single item tests of happiness which were shown not to be reliable over time. The Life Satisfaction Index Z (LSI-Z) was chosen because it measured life satisfaction as evaluated by the respondent and because it was briefer and correlated highly with the original LSI-A constructed by Neugarten and associates (1961).

Self-Rating Depression Scale. The SDS is a 20 item scale developed by W. Zung (1965) to quantitatively assess depression in a subject. Values of 1, 2, 3, and 4 are assigned to a response depending upon whether the item is worded symptomatically positive or symptomatically negative. Ten items (1, 2, 4, 6, 8, 9, 10, 11, 17, 20) are worded positively; for example, for Item 1, I feel down-hearted and blue., a response of: a little of the time, some of the time, good part of the time, or most of the time would be scored 1, 2, 3, and 4 respectively. The ten remaining items are worded negatively; for example, Item 3, Morning is when I feel the best., would be scored 4 for a little of the time, 3 for some of the time, 2 for good part of the time, and 1 for most of the time. An Index for the SDS was derived by dividing the sum of the raw scores on the twenty items by the maximum possible score of 80 and expressed as a decimal; the less depressed the subject, the lower his or her score on the scale.

The SDS scores for a control group of individuals who had no history of recent depressive illnesses and were free of symptoms of depression varied from 0.25 to 0.43 with a mean index of 0.33 (Zung, 1965). The SDS scores for a patient population diagnosed as depressive ranged from 0.63 to 0.90 with a mean index of 0.74 (Zung, 1965). The range of SDS scores of a patient population diagnosed as having other psychiatric disorders was from 0.38 to 0.71 with a mean index of 0.53 (Zung, 1965). Differences between the means of the three groups using the *t* test were statistically significant at the 0.01 level (Zung, 1965). Coleman and Antonucci (1983) reported that the positively worded items correlated highly with SDS as a whole (alpha = .80).

Affect Balance Scale. The ABS was devised by Bradburn and Caplovitz (1965) to measure the psychological well-being of various age groups for National Opinion Research Center studies on happiness. The ABS consists of 10 items that are responded to with a "yes" or "no" depending upon how the subjects felt toward each item in the past month and represents two independent dimensions of well-being. Five items comprise the positive affect dimensions (e.g. Item 1, Particularly excited or interested in something?) and five items comprise the negative affect dimenision (e.g. Item 6, Bored?). Psychological well-being is the balance between the measure of these two dimensions.

The score of well-being is the net index derived from the sum of negative affect items subtracted from the sum of positive affect items, yielding a range of -5 to +5. For convenience, a constant of five is added to this score resulting in a range of 0 to 10. Higher scores reflect more positive well-being. Moriwaki (1974) reports test-retest reliability on the affect items yield values ranging from .80 to .97. She also found that a normal group judged to be physically and mentally healthy had a mean of 8.3. She also supports the validity of the two independent dimensions and suggests that ABS is applicable to all age groups.

Life Satisfaction Index Z. The LSI-Z (Wood, Wylie, & Sheafor, 1969) is a 13 item scale designed to assess psychological well-being on the basis of a cognitive judgment of life satisfaction by the respondent. The LSI-Z was derived from the 20 item Life Satisfaction Index A (Neugarten, Havighurst, & Tobin, 1961), a self-administered instrument developed from and validated against Life Satisfaction Ratings (LSR).

The LSR was obtained from data gathered in extensive and lengthy interviews and rated by clinical psychologists.

Subjects make a check mark in response to each item in one of three spaces: agree, disagree, unsure. The response reflecting higher well-being which may be either an "agree" or "disagree" as indicated in the key, is given a score of two, a score of one is awarded to "unsure" or no response, and a zero is given to responses reflecting less well-being for a range of 0 to 26. Higher scores reflect higher psychological well-being.

Test reliability of the LSI-Z using the Kuder-Richardson Formula 20 Coefficient Alpha was .79 and validity, as measured by correlation with the LSR, was .57 (Wood, Wylie, & Sheafor, 1969). Wylie (1970) found in a group of typical sixty year olds that the mean of the LSI-Z ranged from 18.6 to 18.9.

Measurement of Independent Variables

Questionnaire E. Questionnaire E, designated as Part E in the mailing package to participants, contained various sociodemographic variables whose impact on well-being was to be investigated. Respondents were asked to state their age, marital status, employment status, occupation, student status, volunteer work status, volunteer work hours, date of last menstrual period, menopausal status, educational level, years of schooling, and their total yearly income in three ways (own income combined with partner, own total income, and own income from employment only). Also, respondents were asked to give information on the number of children born to them, the number of stillborns, miscarriages, or abortions, and the number of children presently living

with them, and to indicate whether they were taking estrogen preparations, birth-control pills, tranquillizers, or sleeping pills.

Subjects were placed in one of four categories of menopausal status devised by McKinlay and Jefferys (1974) called premenopausal, transitional menopausal, menopausal, and postmenopausal. Premenopausal is designated if the subject has menstruated within the last three months with NO CHANGE in regularity or volume in the previous year. Transitional menopausal is designated if the subject menstruated within the last three months but with SOME CHANGE in regularity and/or volume in the previous year. Menopausal is designated if the subject last menstruated between three and 12 months ago. Postmenopausal is designated when the subject has menstruated for the last time over one year ago; that is when twelve consecutive months of amenorrhea have occurred. Postmenopausal status may be achieved by natural termination of the menses or by artificial termination as a result of surgery, X-ray, or radium treatment. Postmenopausal indicates the presence of a state of infertility.

Because only 2.9% of the subjects were in the menopausal category, this necessitated the use of a three category classification of menopausal status as delineated by Jaszman, Van Lith, and Zaat in 1969 (Flint, 1979), instead of the four categories originally intended. The three category classification combines transitional and menopausal categories into one category called perimenopausal. Perimenopausal is designated when CHANGES in regularity and/or volume in menstruation have occurred within the past year and is a transitional phase indicating that cessation of menstruation is occurring. In retrospect,

perimenopausal may be a more suitable term because menopause cannot be definitely established until one year of amenorrhea has passed, at which time the individual is than considered postmenopausal.

The utilization of menopausal categories provides for a distinction among the population of midlife women in physiological terms. While the premenopausal and postmenopausal periods allude to physiologically stable periods, the period of time called menopause or perimenopause refers, physiologically, to a time of instability and adjustment (McKinlay & McKinlay, 1973).

Description of Sample

The sample of this study consisted of 105 women, aged 40 to 55 years living in or around Edmonton who volunteered to participate. This age range was chosen because menopause, a focal variable in this study, occurs primarily during this age interval and at an average age of 50 years, the remainder entering by 60 years of age (Kempers, 1977).

The sample is described under the various variable headings.

Age Range. The age range of the sample was 40 to 55 years as requested. Mean age of the sample was 48.1 years, the mode was 47 years, and the majority of the sample, 62.9%, was 49 years or younger.

Menopausal Status. Using the three category classification, the sample is composed of 27 subjects (25.7%) who are in the premenopausal category, 35 (33.3%) who are in the perimenopausal category, and 43 (41.0%) who are in the postmenopausal category. The postmenopausal category consists of 19 subjects who experienced a natural menopause and 24 subjects placed there because of surgical removal of the uterus or ovaries. Thirteen of the latter group had both uterus and ovaries

removed. Eighty-one subjects or 77.1% of the sample did not have any surgery of the uterus or ovaries.

Employment Status. The total percentage of women in the sample who were employed either full-time or part-time is 57.1% and surpasses by 0.5% the figure for the percentage of women over 15 years of age in Canada who are in the labor force. The frequency and percentage in each of the five employment categories is: 35 (33.3%) employed full-time, 25 (23.8%) employed part-time, 33 (31.4%) working in the home full-time, 9 (8.6%) unemployed, and 3 (2.9%) retired.

Occupational Class. A large number of the sample, 42 subjects or 43.8%, come from the managerial and professional class. The frequency and percentage of the sample in the other occupational classes is: 33 subjects (34.4%) in the clerical class, 2 subjects (2.1%) in the sales class, 3 subjects (3.1%) in the service class, 1 subject (1.0%) in primary occupations, and 15 subjects (15.6%) in the homemaker class. As respondents were asked to state their present occupation or previous occupation if retired or unemployed, it appears that some subjects who indicated homemaking as their present employment may have been previously employed or may have been part of the nine respondents who did not indicate their occupational class.

Volunteer Work Variable. A majority of the sample, 57 subjects or 54.8% do no volunteer work while of those who work as volunteers, 2 subjects (1.9%) consider this work as full-time and 45 subjects (42.9%) consider it as part-time work. The hours of volunteer work per week for the sample ranges from zero hours reported by 3 subjects to 30 hours reported by 1 subject; 57 subjects did not reply to this question.

Educational Variables. A large majority of the sample, 87 subjects or 84.5%, do not attend an educational facility; of those attending, 7 subjects (6.8%) attend full-time and 9 subjects (8.7%) attend part-time. The sample's mean for total years of schooling is 14.25 years and may serve to explain the low percentage who are presently attending an educational facility. Thirty-five subjects (33.3%) have a university degree or higher, 17 (16.2%) have some university, 18 (17.1%) have post-high school education, 18 (17.1%) have graduated from high school, and 17 (16.2%) have grades nine to eleven.

Marital Status and Family Variables. The composition of the sample according to marital status is: 2 subjects (1.9%) who are single, 2 subjects (1.9%) common law, 85 subjects (81.0%) married, 1 subject (1.0%) separated, 10 subjects (9.5%) divorced, and 5 subjects (4.8%) widowed.

The sample according to the number of children born consists of 7 subjects (6.7%) producing no children, 11 subjects (10.5%) with one child, 31 subjects (29.5%) with two children, 27 subjects (25.7%) with three children, 20 subjects (19.0%) with four children, and 9 subjects (8.6%) producing 5, 6, 7, or 9 children. Fifty-six subjects (54.4%) experienced no stillborns, miscarriages, or abortions, 28 subjects (27.2%) had one experience, 13 subjects (12.65%) had two experiences, and 6 subjects (5.8%) had three or four stillborns, miscarriages, or abortions. The sample according to the number of children presently living with the respondent consists of 33 subjects (31.7%) who have no children living at home, 33 subjects (31.7%) with one child, 24 subjects (23.1%) with two children, and 14 subjects (13.5%) with 3, 4, or 6 children at home.

Pharmaceutical Consumption. Low consumption of three of four specified pharmaceutics is revealed by the data. No subjects were taking birth-control pills, 5 subjects were taking tranquillizers, and 3 subjects were taking sleeping pills. Twenty-one subjects, 20%of the sample, were taking estrogen preparations and of this number were 16 subjects who had their uterus or both uterus and ovaries removed. A Canada Health Survey reported that 17% of all women aged 45 to 64 years were users of estrogen in 1981 (Kagis, 1984).

Income Status. A large proportion, 69.3% or 70 subjects, reported a combined yearly income (partner and respondent) in excess of $40,000 with 43.6% reporting a combined yearly income of over $50,000. Table 1 shows the frequency and percentage distribution of respondents by the three types of yearly income. No respondents reported their own total yearly income to be over $50,000 and 37 subjects reported their own total yearly income to be $9,999 or less.

Well-Being Variables. Table 2 shows the SDS scores of the sample with a range from 0.25 to 0.71 which denotes a high level of depression. The percentage of the sample who scored above 0.43, the upper range figure of a normal control group, was 34.3%; of this group, 3 subjects were in the range indicated for depressive disorders.

Scores on the ABS, shown in Table 3, ranged from 1 to a value of 10, the highest possible score and the mode for this sample; the mean was 7.5. Only 11.4% of the sample had a score of four or lower on the ABS which signifies the presence of a larger amount of negative affect than positive affect. The percentage of the sample with scores of five which indicates equal amounts of positive and negative affect was 8.6%.

Table 1

Frequency and Percentage Distribution of

Respondents by Income

Income Categories	Types of Yearly Income					
	combined		own total		own employment	
	f	%	f	%	f	%
No income	0	0.0	12	12.0	29	29.3
Less than $9,999	3	3.0	37	37.0	26	26.3
$10,000 to $19,999	6	5.9	19	19.0	18	18.2
$20,000 to $29,999	7	6.9	15	15.0	9	9.1
$30,000 to $39,999	15	14.9	12	12.0	12	12.1
$40,000 to $49,999	26	25.7	5	5.0	5	5.1
Over $50,000	44	43.6	0	0.0	0	0.0
TOTAL	101	100.0	100	100.0	99	100.0
MISSING	4		5		6	

Table 2

Frequency and Percentage Distribution of

Respondents for Depression Scores

Depression	frequency	percentage
.25 - .28	3	2.8
.29 - .32	14	13.3
.33 - .36	33	31.4
.37 - .40	11	10.5
.41 - .44	13	12.3
.45 - .48	12	11.4
.49 - .52	9	8.6
.53 - .56	6	5.8
.57 - .60	1	1.0
.61 - .64	2	1.9
.65 - .68	0	0.0
.69 - .72	1	1.0
TOTAL	105	100.0

Note. Higher scores in this table indicate higher levels of depression and lower levels of well-being.

Table 3

Frequency and Percentage Distribution of Respondents for Affect Balance Scores

Affect Balance	frequency	percentage
1	1	1.0
2	1	1.0
3	2	1.9
4	8	7.6
5	9	8.5
6	14	13.5
7	14	13.5
8	13	12.4
9	17	16.2
10	26	24.8
TOTAL	105	100.0

Note. Higher scores in this table indicate higher levels of well-being.

A majority, 80.0%, had scores of six or greater, indicating a preponderance of positive affect over negative affect.

Table 4 shows the LSI-Z scores of the sample. The range of LSI-Z scores was from 2 to 26, the highest possible score, with the mode at 24; the mean was 19.9.

Although on two of the three scales the well-being scores appeared to be very high, they appear to be due to a ceiling effect in the measuring instruments not a restriction of range because, as shown earlier, other studies found similar high means.

The correlation between depression and affect balance was -.49, between depression and life satisfaction it was -.57, and between affect balance and life satisfaction it was .64. The fact that these numbers are positively correlated supports the assumption that they are measuring the same construct.

Summary of Sample Characteristics

Characteristics which describe the majority of the respondents on various demographic variables are: between the ages of 40 and 49 years, married, employed, educated above high school graduation, wealthy on the basis of yearly income combined with partner, and not wealthy on the basis of yearly income from own employment. The majority of the sample according to family variables is described as: having three or fewer children born to them; having no stillborns, miscarriages, or abortions; and having one or no children living at home. Low consumption of tranquillizers and sleeping pills was reported by the respondents; no subjects were taking birth-control pills. The majority were not taking estrogen and did not have hysterectomies or

Table 4

Frequency and Percentage Distribution of Respondents for Life Satisfaction Scores

Life Satisfaction	frequency	percentage
1 - 2	1	1.0
3 - 4	1	1.0
5 - 6	2	1.9
7 - 8	3	2.8
9 - 10	3	2.8
11 - 12	3	2.8
13 - 14	5	4.8
15 - 16	7	6.7
17 - 18	7	6.7
19 - 20	8	7.7
21 - 22	20	19.1
23 - 24	27	25.7
25 - 26	18	17.1
TOTAL	105	100.0

Note. Higher scores in this table indicate higher levels of well-being.

ovarectomies. However, the subjects with hysterectomies and ovarectomies formed the majority of the postmenopausal group. A large majority of the sample were not attending educational facilities and a slight majority were not involved in volunteer work. A large percentage of the sample, but not a majority, were in management and professional occupations.

Approximately one-third of the sample have depression scores on the SDS that are above the upper range limit for a normal control group. However, a large number of subjects are grouped at the higher levels of well-being as measured by the ABS and the LSI-Z so that the majority of the respondents may be described as having fairly high levels of well-being.

Analysis of Data

To describe the characteristics of the sample in terms of means and ranges, the SPSSx general statistics program was used.

One-way analysis of variance was performed on eight variables with each of the three dependent variables. Pearson product-moment correlations on twelve variables and *t* tests on six variables were performed with each of the three dependent variables.

CHAPTER IV

RESULTS

This chapter presents the results, followed by evaluative comments, of the investigations carried out to address each of the research question concerning the well-being of midlife women.

Relationship Between Well-Being and Menopausal Status

The first research question asked whether well-being in midlife women was reduced during the perimenopausal phase in contrast to the premenopausal and postmenopausal phases. Table 5 shows the well-being means of the sample for each of the three menopausal phases and the means for the three subgroups of the postmenopausal category. The one-way analyses of variance indicated that the three groups did not differ significantly on depression, $F(2, 102) = 1.19$, $p > .05$, on affect balance, $F(2, 102) = .08$, $p > .05$, or on life satisfaction, $F(2, 102) = .36$, $p > .05$. These results indicate that well-being is not reduced during the perimenopausal phase.

The one-way analyses of variance performed when the three subgroups of the postmenopausal phase were considered, indicated that the five groups did not differ significantly on depression, $F(4, 100) = .62$, $p > .05$, on affect balance, $F(4, 100) = .06$, $p > .05$, or on life satisfaction, $F(4, 100) = .40$, $p > .05$. These results indicate that well-being is not influenced by the way in which postmenopausal status was achieved.

Table 5

Well-Being Means of Sample by Menopausal Status

Menopausal Status	n	Depression	Affect Balance	Life Satisfaction
Premenopausal	27	37.9	7.5	20.2
Perimenopausal	35	41.3	7.4	20.4
Postmenopausal				
Entire Sample	43	40.1	7.5	19.4
Uterus and Ovaries Intact	19	39.7	7.5	18.7
Uterus Only Removed	11	40.0	7.5	20.7
Uterus and Ovaries Removed	13	40.9	7.6	19.2

Note. Higher scores on depression indicate lower well-being; higher scores on affect balance and life satisfaction indicate higher well-being.

Relationship Between Well-Being and Employment Status

The second research question asked whether midlife women employed outside the home experienced higher levels of well-being than homemakers. Table 6 shows the well-being means of the sample for each of the five employment groups. However, the means of only the three employment categories of full-time, part-time, and homemakers as specified in the second research question were compared in the one-way analysis of variance. The one-way analyses of variance indicated that the three groups specified for the research question did not differ significantly on depression, $F(2, 90) = .44$, $p > .05$, on affect balance, $F(2, 90) = .18$, $p > .05$, or on life satisfaction, $F(2, 90) = .55$, $p > .05$. These results indicate that midlife women employed outside the home in either full-time or part-time employment do not experience higher levels of well-being than homemakers.

Well-Being as Related to Various Variables

The third research question considered the relationship between well-being in midlife women and various variables (age, marital status, occupational class, student status, volunteer status, volunteer hours of work, family, hysterectomy, ovarectomy, educational level, years of schooling, pharmaceutical consumption of estrogen, birth-control pills, tranquillizers, and sleeping pills, and yearly incomes according to three types.

Table 7 shows the correlation coefficients of the sample for measures of well-being and seven variables. Two results in Table 7 are significant at the .01 level. The correlation of .25 between depression and the number of stillborns, miscarriages, or abortions,

Table 6

Well-Being Means of Sample by Employment Status

Employment Status	n	Depression	Affect Balance	Life Satisfaction
Full-time	35	38.7	7.6	20.1
Part-time	25	40.6	7.8	21.3
Homemaker	33	38.9	7.5	20.0
Unemployed	9	43.1	6.2	18.8
Retired	3	51.7	6.7	9.7

Note. Higher scores on depression indicate lower well-being; higher scores on affect balance and life satisfaction indicate higher well-being.

Table 7

Correlation Coefficients of Sample for

Measures of Well-Being

	Depression	Affect Balance	Life Satisfaction
Age of Subject	.03 (n = 105)	.09 (n = 105)	.04 (n = 105)
Number of Children Born	.03 (n = 105)	.06 (n = 105)	.01 (n = 105)
Stillborns, Miscarriages, Abortions	.25* (n = 103)	-.05 (n = 103)	-.01 (n = 103)
Number of Children at Home	-.04 (n = 104)	-.01 (n = 104)	.00 (n = 104)
Volunteer Hours	.05 (n = 48)	.23 (n = 48)	.11 (n = 48)
Years of Schooling	-.06 (n = 103)	.07 (n = 103)	.24* (n = 103)

* $p < .01$

indicates that the level of depression increases as the number of stillborns, miscarriages, or abortions increases. The correlation of .24 between life satisfaction and years of schooling indicates that life satisfaction increases with an increase in the years of schooling. No other correlations in Table 7 are significant, even at the .05 level.

One-way analyses of variance indicated that no significant differences in well-being existed between groups in marital status, volunteer status, student status, or the three types of income. T tests indicated that no significant differences in well-being existed between the dichotomous groups on the variables of hysterectomy, ovarectomy, consumption of estrogen, consumption of tranquillizers, and consumption of sleeping pills. No comparison was possible for the consumption of birth-control pills as only one group, those not taking, existed.

Summary of the Results

A correlation between depression and the number of stillborns, miscarriages, or abortions, $r = .25$, $p < .01$, and a correlation between life satisfaction and years of schooling, $r = .24$, $p < .01$, were the only statistically significant relationships in my study and provided an answer to the third research question that a relationship between well-being and these two variables exists. No other correlations or relationships were found between well-being and the variables of marital status, volunteer status, student status, three types of income, hysterectomies, ovarectomies, or consumption of estrogen, birth-control pills, tranquillizers, and sleeping pills.

The result that no significant differences exist among menopausal groups indicated that the perimenopausal group does not experience lower levels of well-being in contrast to the premenopausal and postmenopausal groups.

The result that no significant differences exist among employment groups indicated that midlife women employed outside the home do not experience greater levels of well-being than homemakers.

CHAPTER V

DISCUSSION

The present study addressed three research questions dealing with factors that may be related to psychological well-being in midlife women. A discussion of these questions and the findings associated with them will be presented first in this chapter, followed by a discussion of the limitations of the study and by the conclusions and future research directions section.

Menopausal Status as a Factor in Well-Being

The first research question asked: Is well-being in midlife women reduced during the perimenopausal phase in contrast to the premenopausal and postmenopausal phases? To answer this question, subjects in a voluntary sample of women aged 40 to 55 years were placed into one of three menopausal phases on the basis of an objective definition involving information of the regularity, volume, and date of menses. The results definitively indicated that the three groups were not significantly different on the three different indicators of well-being. Clearly, well-being in the perimenopausal phase is not reduced in contrast to the premenopausal and postmenopausal phases.

Several reasons may be advanced to account for this finding that the perimenopausal phase is not a time of lowered well-being. One possible reason is that there is truly no relationship between menopausal status and well-being. Another possible explanation is that there is a relationship but I failed to discover it. However,

the replication of no relationship using three instruments measuring three different aspects of well-being reinforces the finding that all three menopausal categories have similar levels of well-being. Another possible reason was the restricted range of scores on the well-being instruments. However, the mean scores in my sample were comparable to those of other investigators.

Other information from my study can help explain why menopausal status has little or no effect on well-being. Primarily, this sample does not seem to be threatened by the end of their reproductive capacity, a condition associated negatively with the menopause. That three or fewer children were born to 72% of the sample seems to indicate an intention for smaller family size and for control of fecundity. Also, the finding that no subjects use birth-control pills supports rather than contradicts the presence of reproductive control. The dangerous side-effects of birth-control pills for older women presumably may be known by this well-educated sample and alternative birth-control measures may substitute for the pills. Finally, well-being of women with surgery of the uterus and/or ovaries in this sample is not significantly different from women without surgery, suggesting that loss of reproductive capacity may not reduce well-being in this sample.

Contrary to popular misconception, menopausal status was found to have no effect on well-being in my sample of midlife women. Therefore, use of the words menopause or menopausal as synonyms for the midlife period of women should be discouraged as menopausal status appears not to be the prominent factor distinguishing this period of life for women.

Employment as a Factor in Well-Being

The second research question asked: Do midlife women who are employed outside the home in either full-time or part-time work experience higher levels of well-being than homemakers? For each of the three measures I used, the results indicated that the three groups did not differ significantly on well-being.

This finding that full-time workers, part-time workers, and homemakers have similar levels of well-being suggests that employment status, simply conceived, is not a major influence on well-being among relatively affluent and well-educated women in midlife. Other influences in these women's lives may minimize or overshadow the simple effects of employment on well-being.

A cohort interpretation would suggest that subjects in this sample were entering their second decade of life, when marriage and employment decisions are made, between the years 1950 and 1965. During this period of time, the homemaker image as a fulfilling endeavor was undergoing changes, whereas work for women was not yet considered as essential and important as it is for men. Thus, this cohort of women may espouse positive notions of all three employment categories considered in the research question. The category chosen would depend upon the life circumstance in which the woman finds herself. As the income levels of this sample are high, the economic necessity to work is not present and employment will be chosen for the well-being benefits. Similarly, as the child care demands of this sample have decreased with almost two-thirds of the subjects having one or no children at home, the opportunity for choice of employment exists and the choice will

again be based on the benefits that each category offers. Well-being levels for homemakers, full-time workers, and part-time workers in this sample might be similar because subjects have selected the category that would provide the most benefits at this time in their lives.

Thus, it appears that employment status does not effect well-being in this sample as the three employment categories might contain features which the subjects in each category perceive as beneficial for them at this time in their lives.

The Effect of Other Factors on Well-Being

The third research question asked: Does a relationship exist between well-being in midlife women and other variables (age, marital status, occupational class, student status, volunteer status, volunteer hours of work, family, hysterectomy, ovarectomy, educational level, years of schooling, pharmaceutical consumption of estrogen, birth-control pills, tranquillizers, and sleeping pills, and yearly income according to three types) investigated in this study. Only two significant relationships were found.

The first finding was the weak, but significant, correlation between depression and the number of stillborns, miscarriages, or abortions that may be interpreted as an experience of a felt loss. However, no information exists as to the nature of this loss, as to when this event occurred, under what life circumstances it occurred, and the intensity of the event. As all subjects but one who experienced this loss produced other children, loss of the maternal role may not have been implicated. Thus, the reason for the depression cannot be provided from the existing data and represents the failure of simple

relationships to explain complex behavior.

Similarly, the second significant finding of the correlation between life satisfaction and years of schooling suggests that women in this sample obtained values that extended beyond the economic utility of education but the nature of these values cannot be interpreted from the existing data. Education means more than the number of years of schooling. If the nature of this variable is implicated with qualities such as pride or self-esteem, the variable expressed in terms of a simple relationship with time is insufficient for a clear explanation.

Inability of other variables in this study to show effects may also be a consequence of the use of them as simple relationships. A simple designation is not sufficient for differentiation as adequate investigation requires the use of variables possessing more detailed dimensions. In particular, volunteer status or student status may be too simple because dimensions such as degree of involvement or commitment are neglected.

Limitations of the Study

A major limitation of this study is the nonrepresentativeness of the sample. The majority of the sample share properties that may enhance well-being, whereas women without these qualities are underrepresented. Acquiring subjects for a study by voluntary participation tends to attract individuals who are more healthy and more active than non-participants. A possible self-selecting bias in this sample prevents generalizing to midlife women. However, although generalizations to all women in the midlife are not possible, the

study does represent progress in moving away from the study of clinical populations toward investigating segments of general and well populations.

Another limitation is the use of two instruments with dichotomous and trichotomous scales that fail to provide a wider range of intensity that would differentiate subjects more adequately.

Conclusions and Future Research Directions

The major objective of this study was to explore the effects of menopausal status and employment on the psychological well-being of women at midlife. Although the levels of well-being in my sample of midlife women, regardless of their menopausal or employment status, appeared to be high, a comparison with previous findings suggest that they are fairly typical. The generally minimal effects of menopausal and employment status suggest that these factors may not be major influences in the lives of these midlife women.

The findings of similar well-being means on all three dependent variable measurements among the menopausal groups indicate that menopausal groups do not differ on levels of well-being and that the myth of reduced well-being during the menopausal or perimenopausal phase may be unfounded. These findings suggest that a positive connotation of midlife for women should be substituted for the present misconceptions.

Similar levels of well-being on all three measures among the three employment groups studied indicate that employment status does not differentiate this sample of women. The benefits from each of these three work roles appears to depend upon life circumstances governing

entry into or from employment and upon the generational effect defining the value of homemaking and of work outside the home. A deeper examination of these situations is needed to verify the effect of employment.

Simple relationships were found to be inadequate to explain the effects of the family variable dealing with stillborns, miscarriages, or abortions on depression or the effects of years of schooling on life satisfaction. A more in-depth perspective of the nature of these variables is required.

The results of this study suggest that the well-being of midlife women is a complex phenomenon and that simplistic relationships are inadequate in investigations of this construct. Urgently needed is a theory of women in the middle years to serve as a framework in linking the numerous elements of well-being and to provide an alternative to theories that are based on male models. Theoretical statements would determine which dimensions of the elements should be studied and which design would be best suited to examine the questions. In particular, longitudinal studies are recommended to ascertain the existence of patterns and sequences.

Also, future research should not focus on traditionally female issues such as "empty nest", a narrow focus that neglects the complexities of midlife women. Important distinctions regarding employment for women need to be studied. Difficulties in the present study arose in regard to application of conventional employment categories to classify women's experiences with employment. Unclear are the particular circumstances defining retired or unemployed in this study.

Should the working woman who leaves work in her late twenties to raise a family be categorized as retired or unemployed when she is in her forties? Other concerns are the use of homemaker as an employment category and the use of the status of previously employed homemaker and homemaker who has never been employed. The effects of education on well-being in midlife women requires further investigation of its importance to life satisfaction.

Finally, the study of depression in midlife women deserves attention. In the present study, over one-third of the subjects were above the range of a normal control group and a peculiar relationship between depression and well-being depicted by a combination of high depression means with high well-being means was seen in some groups in this study. The correlation between depression and the number of stillborns, miscarriages, or abortions demands investigation so that effects of this family variable on depression may be identified early to prevent extensions of the effects into the middle years.

BIBLIOGRAPHY

Atchley, R. C. (1977). The social forces in later life: An introduction to social gerontology (2nd ed.). Belmont, CA: Wadsworth.

Ballinger, C. B. (1975). Psychiatric morbidity and the menopause: Screening of the gerneral population sample. British Medical Journal, 276, 344-346.

Bart, P. (1972). Depression in middle-aged women. In J. M. Bardwick (Ed.), Readings on the psychology of women (pp. 134-142). New York: Harper & Row.

Bart, P & Grossman, M. (1978). Menopause. In M. T. Notman & C. C. Naderlson (Ed.), The woman patient: Medical and psychological interfaces (pp. 337-354). New York: Plenum.

Barnett, R. C. & Baruch, G. K. (1978). Women in the middle years: A critique of research and theory. Psychology of Women Quarterly, 3, 187-197.

Beiser, M. (1974). Components and correlates of well-being. Journal of Health and Social Behavior, 15, 320-327.

Black, S. M. & Hill, C. E. (1984). The psychological well-being of women in their middle years. Psychology of Women Quarterly, 8, 282-292.

Borland, D. C. (1982). A cohort analysis approach to the empty-nest syndrome among three ethnic groups of women: A theoretical position. Journal of Marriage and the Family, 44, 117-130.

Bradburn, N. M. (1969). The structure of psychological well-being. Chicago: Aldine.

Bradburn, N. M. & Caplovitz, D. (1965). Reports on happiness: A pilot study of behavior related to mental health. CHicago: Aldine.

Briggs, P. F., & Laperriere, R., & Greden, J. (1965). Working outside the home and the occurrence of depression in middle-aged women. Mental Hygiene, 49, 438-442.

Bungay, G. T., Vessey, M. P., & McPherson, C. R. (1980). Study of symptoms in middle age with special reference to the menopause. British Medical Journal, 281, 181-183.

Campbell, A. (1976). Subjective measures of well-being. American Psychologist, 31, 117-124.

Carey, R. G. (1977). The widowed: A year later. Journal of Counseling Psychology, 24, 125-133.

Carney, P. (1982, December). Counselling the menopausal woman. In Psychological aspects in obstetrics and gynecology. Symposium conducted at the Misericordia Hospital, Edmonton.

Cherry, S. (1976). The menopause myth. New York: Ballantine Books.

Coleman, L. M. & Antonucci, T. C. (1983). Impact of work on women at midlife. Developmental Psychology, 19, 290-294.

Cooke, D. J. & Greene, J. G. (1981). Types of life events in relation to symptoms at the climacterium. Journal of Psychosomatic Research, 25, 5-11.

Cutler, S. (1973). Volunteer association participation and life satisfaction: A research note. Journal of Gerontology, 28, 96-100.

Cutler, W., Garcia, C., & Edwards, D. (1983). Menopause: A guide for women and the men who love them. New York: W. W. Horton and Co.

De Alvarez, R. (1977). Textbook of gynecology. Philadelphia: Lea & Febiger.

Deutsch, H. (1945). The psychology of women. New York: Grune & Stratton.

Diener, E. (1984). Subjective well-being. Psychological Bulletin, 95, 542-575.

Diers, C. J. (1974). Historical trends in the age at menarche and menopause. Psychological Reports, 34, 931-937.

Ferree, M. M. (1976). Working-class jobs: Housework and paid work as sources of satisfaction. Social Problems, 51, 431-441.

Flint, M. (1975). The menopause: Reward or punishment? Psychosomatics, 16, 161-163.

Flint, M. (1979). Transcultural influences in perimenopause. In A. A. Haspels & H. Musaph (Eds.), Psychosomatics in perimenopause (pp. 41-56). Baltimore: university Park Press.

Fuchs, E. (1977). The second season: Life, love, and sex; women in the middle years. Garden City, N. Y.: Anchor Press.

Glenn, N. D. (1975a). The contribution of marriage to the psychological well-being of males and females. Journal of Marriage and the Family, 37, 591-600.

Glenn, N. D. (1975b). Psychological well-being in the post-parental stage. Journal of Marriage and the Family, 37, 105-110.

Glenn, N. D. & Weaver, C. N. (1981). Education's effects on psychological well-being. Public Opinion Quarterly, 45, 22-39.

Gove, W. R. (1972). The relationship between sex roles, marital status, and mental illness. Social Forces, 23, 34-44.

Greene, J. G. & Cooke, D. J. (1980). Life stress and symptoms at the climacterium. British Journal of Psychiatry, 136, 486-489.

Hare-Mustin, R. (1983). An appraisal of the relationship between women and psychotherapy: 80 years after the case of Dora. American Psychologist, 28, 593-601.

Harkins, E. B. (1978). Effects of empty nest transition on self-reports of psychological and physical well-being. Journal of Marriage and the Family, 40, 549-556.

Ibrahim, M. A. (1980). The changing health state of women. American Journal of Public Health, 70, 120-121.

Ivancevich, J. M. & Matteson, M. T. (1982). Occupational stress, satisfaction, physical well-being and coping: A study of homemakers. Psychological Reports, 50, 995-1005).

Jaslow, P. (1976). Employment, retirement, and morale among older women. Journal of Gerontology, 31, 212-218.

Kagis, M. (1984). Estrogen replacement therapy and menopause. In Mid-Life wellness for women. Workshop conducted at the University of Alberta, Edmonton.

Kempers, R. (1977). The menopause. In R. De Alvarez (Ed.), Textbook of Gynecology (pp. 209-215). Philadelphia: Lea & Febiger.

Kozma, A. & Stones, M. J. (1980). The measurement of happiness: Development of the Memorial University of Newfoundland scale of happiness (MUNSCH). Journal of Gerontology, 35, 906-912.

Larson. R. (1978). Thirty years of research on the subjective well-being of older Americans. Journal of Gerontology, 33, 109-125.

Lawton, M. P. (1983). Environmental and other determinants of well-being in older people. Gerontologist, 23, 349-357.

Lax, R. (1982). The expectable depressive climacteric reaction. Menninger Clinic Bulletin, 46(2), 151-167.

Lohmann, N. (1977). Correlations of life satisfaction, morale, and adjustment measures. Journal of Gerontology, 32, 73-75.

Lohmann, N. (1980). Life satisfaction research in aging: Implications for policy development. In N. Datan and N. Lohmann (Eds.), Transitions of aging. New York: Academic.

Lowenstein, S. F., Bloch, N. E., Campion, J., Epstein, J. S., Gale, P., & Salvatore, M. (1981). A study of satisfactions and stresses of single women in midlife. Sex Roles, 7, 1127-1141.

Marx, J. L. (1979). Hormones and their effects in the aging body. Science, 206, 805-806.

Maynard, F. Good news about menopause. Chatelaine, October, 1981, pp. 69, 127-130.

MacPherson, K. I. (1981). Menopause as a disease: The social construction of a metaphor. Advances in Nursing Science, 3, 95-113.

McKinlay, S. M. & Jefferys, M. (1974). The menopausal syndrome. British Journal of Preventive and Social Medicine, 28, 108-115.

McKinlay, S. M., Jefferys, M., & Thompson, B. (1972). An investigation of the age at menopause. Journal of Biosocial Medicine, 4, 161-173.

McKinlay, S. M. & McKinlay, J. B. (1973). Selected studies of the menopause. Journal of Biosocial Science, 5, 533-555.

Mendelsohn, R. S. (1981). Male practice: How doctors manipulate women. Chicago: Contemporary Books, Inc.

Miller, G. (1981). Its a living: Work in modern society. New York: St. Martin's Press.

Moriwaki, S. Y. (1974). The affect balance scale: A validity study with aged sample. Journal of Gerontology, 29, 73-78.

Mostow, E. & Newberry, E. (1975). Work role and depression in women: A comparison of workers and housewives in treatment. American Journal of Orthopsychiatry, 45, 538-548.

Munro, A. (1969). Psychiatric illness in gynaecological out-patients: A preliminary study. British Journal of Psychiatry, 125, 807-809.

Neff, W. S. (1977). Work and human behavior. Chicago: Aldine.

Nellis, M. (1980). The female fix. Boston: Houghton Mifflin.

Neugarten, B. K., Havighurst, R. J., & Tobin, S. S. (1961). The measurement of life satisfaction. Journal of Gerontology, 16, 134-143.

Neugarten, B. L. & Kraines, R. J. (1965). Menopausal symptoms in women of various ages. Psychosomatic Medicine, 37, 266-273.

Neugarten, B. L., Wood, V., Kraines, R. J., & Loomis, R. (1975). Women's attitudes toward the menopause. In B. L. Neugarten (Ed.), Middle-age and ageing (pp. 195-200). Chicago: University of Chicago.

Notman, M. (1979). Midlife concerns of women: Implications of the menopause. American Journal of Psychiatry, 136, 1270-1274.

Parlee, M. (1976). Social factors in the psychology of menstruation, birth, and menopause. Primary Care, 3, 477-490.

Polit, D. F. & LaRocco, S. A. (1980). Social and psychological correlates of menopausal symptoms. Psychosomatic Medicine, 42, 335-345.

Posner, J. (1979). It's all in your head: Feminist and medical models of menopause (strange bedfellows). Sex Roles, 1, 249-265.

Radloff, L. S. (1975). Sex differences in depression: The effects of occupation and marital status. Sex Roles, 1, 249-265.

Radloff, L. S. (1980). Depression and the empty nest. Sex Roles, 6, 775-781.

Robinson, J. P. & Shaver, P. R. (1976). Measures of social psychological attitudes. Ann Arbour: University of Michigan.

Scarf, M. (1981). Unfinished business. New York: Ballantine Books.

Sontag, S. The double standard of aging. Saturday Review, September, 1972, pp. 29-38.

Sherman, B. M., Wallace, R. B., Bean, J. A., Chang, Y., & Schlabaugh, L. (1981). The relationship of hot flushes to medical and reproductive experience. Journal of Gerontology, 36, 306-309.

Statistics Canada (1982). Census of Canada, 1981. Ottawa: Minister of Supply and Services.

Spreitzer, E., Snyder, E. E., & Larson, D. (1975). Age, marital status, and labor force participation as related to life satisfaction. Sex Roles, 1, 235-247.

Thompson, B., Hart, S. A., & Durno, D. (1973). Menopausal age and symptomatology in a general practice. Journal of Biosocial Medicine, 5, 71-82.

Vancouver Women's Health Collective (1984). Menopause: A self-help approach. Vancouver, B.C.: Vancouver Women's Health Collective.

Warr, P. B. (1978). A study of psychological well-being. British Journal of Psychology, 69, 11-121.

Warr, P. B. (1982). Psychological aspects of employment and non-employment. Psychological Medicine, 12, 7-11.

Warr, P. B. & Parry, G. (1982). Paid employment and women's psychological well-being. Psychological Bulletin, 3, 498-516.

Weideger, P. (1980). Menstruation and menopause: The physiology and psychology, the myth and reality. New York: Alfred A. Knopf.

Weissman, M. (1979). The myth of involutional melancholia. Journal of the American Medical Association, 242, 742-744.

Welch, S. & Booth, A. (1977). Employment and health among married women with children. Sex Roles, 3, 385-397.

Wilson, R. A. (1966). Feminine forever. New York: M. Evan & Company.

Wright, J. D. (1978). Are working women really more satisfied? Journal of Marriage and the Family, 40, 301-313.

Wood, V., Wylie, M. L., & Sheafor, F. (1969). An analysis of a short self-report measure of life satisfaction: Correlation with rater judgments. Journal of Gerontology, 24, 465-469.

Wylie, M. L. (1970). Life satisfaction as a program impact criterion. Journal of Gerontology, 25, 36-40.

Zung, W. W. K. (1965). A self-rating depression scale. Archives of General Psychiatry, 12, 63-70.

APPENDIX A

November 14, 1984

Dear Participant,

This survey is designed to gather some information on attitudes, feelings, and concerns of women aged 40 to 55 years. The results will contribute to our understanding of well-being in women at mid-life.

I am a candidate for the M.Ed. at the University of Alberta. The study is being supervised by Dr. R. Frender, a professor in the Department of Educational Psychology at the University of Alberta.

Please read the following instructions before opening the the envelope containing the two sections of the survey.

1. **COMPLETE SECTION #1 (Parts A, B, and C) BEFORE LOOKING AT SECTION #2. This is necessary to ensure the validity of our results.**

2. After finishing Section #1, then complete Section #2 (Parts D and E).

3. When you have completed both surveys, return them to me in the stamped, self-addressed envelope.

4. To ensure your anonymity, please do not put your name on either the surveys or the return envelope.

Although it would be most helpful to us if you could answer all questions, you may omit any that are objectionable to you.

We would appreciate your returning the surveys at your earliest convenience. If you have any questions, feel free to contact me at 466-9972.

Thank you for your cooperation in this project.

Sincerely,

Olga A. Wiskel

PART A

Here are some statements about how a person feels. Check the statement that applies to you at the present time: a little of the time, some of the time, good part of the time, or most of the time. Please answer every question.

	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.	___	___	___	___
2. Morning is when I feel the best.	___	___	___	___
3. I have crying spells or feel like it.	___	___	___	___
4. I have trouble sleeping at night.	___	___	___	___
5. I eat as much as I used to.	___	___	___	___
6. I still enjoy sex.	___	___	___	___
7. I notice that I am losing weight.	___	___	___	___
8. I have trouble with constipation.	___	___	___	___
9. My heart beats faster than usual.	___	___	___	___
10. I get tired for no reason.	___	___	___	___
11. My mind is as clear as it used to be.	___	___	___	___
12. I find it easy to do the things I used to do.	___	___	___	___
13. I am restless and can't keep still.	___	___	___	___
14. I feel hopeful about the future.	___	___	___	___
15. I am more irritable than usual.	___	___	___	___
16. I find it easy to make decisions.	___	___	___	___
17. I feel that I am useful and needed.	___	___	___	___
18. My life is pretty full.	___	___	___	___
19. I feel that others would be better off if I were dead.	___	___	___	___
20. I still enjoy the things I used to do.	___	___	___	___

PART B

DIRECTIONS: We are interested in the way people are feeling these days. Looking at your present life situation, have you in the past month, ever felt:

	YES	NO
1. Particularly excited or interested in something?	___	___
2. So restless that you couldn't sit long in a chair?	___	___
3. Proud because someone complimented you on something you had done?	___	___
4. Very lonely or remote from other people?	___	___
5. Pleased about having accomplished something?	___	___
6. Bored?	___	___
7. On top of the world?	___	___
8. Depressed or very unhappy?	___	___
9. That things were going your way?	___	___
10. Upset because someone criticized you?	___	___

PART C

Please read each statement on the list:

a. If you agree with it, put a check mark in the space under "AGREE".
b. If you do not agree with a statement, put a check mark in the space under "DISAGREE".
c. If you are not sure one way or the other, put a check mark under "UNSURE".

Please answer every question on the list.

	AGREE	DISAGREE	UNSURE
1. As I grow older, things seem better than I thought they would be.	___	___	___
2. I have gotten more of the breaks in life than most of the people I know.	___	___	___
3. This is the dreariest time of my life.	___	___	___
4. I am just as happy as when I was younger.	___	___	___
5. These are the best years of my life.	___	___	___
6. Most of the things I do are boring or monotonous.	___	___	___
7. The things I do are as interesting to me as they ever were.	___	___	___
8. As I look back on my life, I am fairly well satisfied.	___	___	___
9. I have made plans for things I'll be doing a month or year from now.	___	___	___
10. When I think back over my life, I didn't get most of the important things I wanted.	___	___	___
11. Compared to other people, I get down in the dumps too often.	___	___	___
12. I've gotten pretty much what I expected out of life.	___	___	___
13. In spite of what people say, the lot of the average person is getting worse not better.	___	___	___

PART E

INSTRUCTIONS: Complete the blanks below where required or circle the correct response that applies to you when several choices are given.

1. Year of Birth_____

2. Marital Status

   a. single

   b. married

   c. divorced

   d. separated

   e. widowed

3. Number of children born to you_____

4. Number of stillborns, miscarriages, abortions_____

5. Number of children presently living with you_____

6. Which of these best describes your current employment situation?

   a. Employed full-time

   b. Employed part-time

   c. Unemployed

   d. Retired

   e. Employed full-time but not at work because of temporary illness, strike, etc..

   f. Employed part-time but not at work because of temporary illness, strike, etc.

   g. Taking care of the household

7. What is your present occupation or work (or if retired or unemployed, your previous work)?

   _____

8. Are you currently in school or other educational facility?

   a. Yes, full-time

   b. Yes, part-time

   c. No

PLEASE TURN PAGE OVER

9. Are you currently engaged in volunteer work?

   a. Yes, full-time

   b. Yes, part-time

   c. No

10. If you are a volunteer, how many hours a week, approximately, do you devote to volunteer work?_____

11. What was the month and year of your last menstrual period?

    _____

12. Which condition would describe you at this time?

    a. Menstruated in the last three months with NO CHANGE in regularity or volume in the previous year.

    b. Menstruated within the last three months but with SOME CHANGE in regularity and volume in the previous year.

    c. Last menstruated between three and 12 months ago.

    d. Menstruated last over 1 year ago.

13. Have you had your uterus removed?

    a. Yes

    b. No

14. Have you had your ovaries removed?

    a. Yes

    b No

15. Are you presently taking estrogen or estrogen products such as Premarin?

    a. Yes

    b. No

       If yes, give reason_____

16. Are you presently taking birth-control pills?

    a. Yes

    b. No

       If yes, give reason_____

17. **Are you presently taking tranquillizers?**

    a. Yes

    b. No

    If yes, give reason_____

18. **Are you presently taking sleeping pills?**

    a. Yes

    b. No

19. **What is the highest level of education that you have attained?**

    a. No formal education

    b. 1-8 grades

    c. 9-11 grades

    d. High School graduation

    e. Post high school education(non-university) Please specify_____

    f. Some university

    g. University degree or higher

20. **In total, how many complete years of schooling?**_____

21. **Which of the following best describes the COMBINED total yearly income of you and your partner? Include all sources such as wages, salaries, income from investment, interest, etc.**

    a. No income

    b. Less than $9,999

    c. $10,000 to $19,999

    d. $20,000 to $29,999

    e. $30,000 to $39,999

    f. $40,000 to $49,999

    g. Over $50,000

PLEASE TURN PAGE OVER

22. Which of the following best describes your OWN TOTAL yearly income (DO NOT INCLUDE PARTNER'S INCOME). Include all sources such as wages, salaries, income from investments, interest, etc.

a. No income

b. Less than $9,999

c. $10,000 to $19,999

d. $20,000 to $29,999

e. $30,000 to $39,999

f. $40,000 to $49,999

g. Over $50,000

23. About how much of your OWN yearly income is from your employment only?

a. No income

b. Less than $9,999

c. $10,000 to $19,999

d. $20,000 to $29,999

e. $30,000 to $39,999

f. $40,000 to $49,999

g. Over $50,000

THANK YOU FOR TAKING THE TIME TO COMPLETE THE QUESTIONNAIRES.